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A STUDY OF FIFTY-SEVEN PATIENTS ADMITTED TO THE  
TUMOR CLINIC OF THE MASSACHUSETTS MEMORIAL HOSPITALS

January 3, 1947 to June 27, 1947

Barus, Director of Social Services, and  
Miss Rebecca Pottle, Project Worker, both  
of whom are on the staff of the Massachu-  
setts Memorial Hospital.

A Thesis

Submitted by

Maureen Elizabeth Ross

(A.B., College of New Rochelle, 1946)

In Partial Fulfillment of Requirements for  
the Degree of Master of Science in Social Service

1948





## TABLE OF CONTENTS

### CHAPTER

PAGE

#### I INTRODUCTION

Purpose of Study

Scope of Study

Methods of Gathering Data

Limitations of Study

Purpose and Organization

The writer gratefully acknowledges the generous assistance of Miss Deborah Barus, Director of Social Service; and Miss Rebecca Poole, Social Worker, both of whom are on the staff of the Massachusetts Memorial Hospitals.

The Present State of Medical Science in Regard to Cancer as a Disease

Geographical Differences in Cancer Incidence

Prevention of Cancer

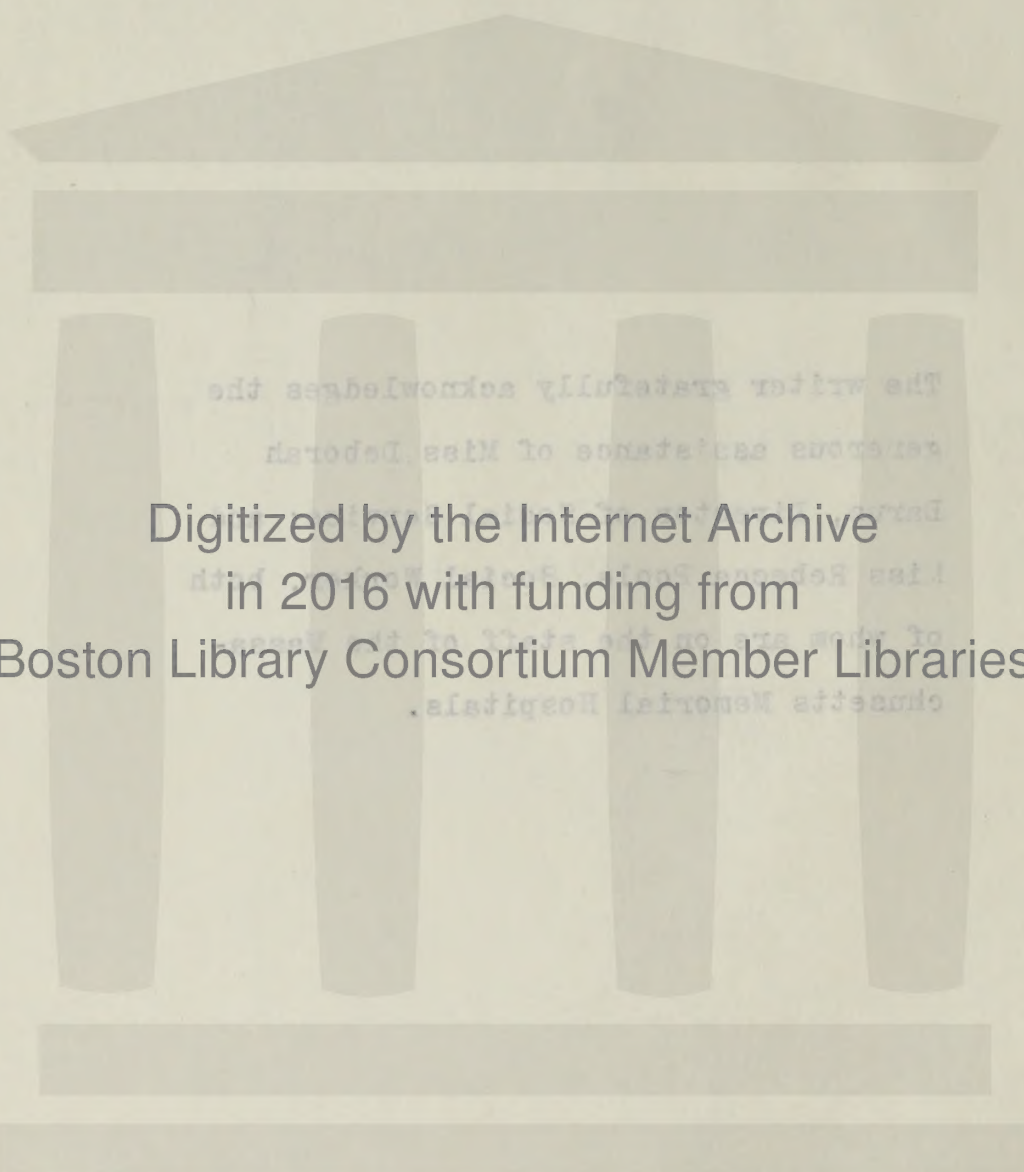
The Cancer

Symptoms

Diagnosis

Treatment

World-Wide Problem



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## TABLE OF CONTENTS

CHAPTER	(Continued)	PAGE
I	INTRODUCTION	
	Purpose of Study	1
	Scope of Study	2
	Methods of Gathering Data	2
	Limitations of Study	3
	Purpose and Organization of Clinic	5
	Importance of Study	7
II	MEDICAL INFORMATION ON BENIGN AND MALIGNANT TUMORS	9
	Definition of a Tumor	9
	Benign Tumors	9
	Malignant Tumors	10
	The Present State of Medical Science in Regard to Cancer as a Disease	11
	Geographical Differences in Cancer Incidence	11
	Prevention of Cancer	12
	The Causes	13
	Symptoms	16
	Diagnosis	18
	Treatment	20
	World-Wide Problem	21





## TABLE OF CONTENTS

CHAPTER		PAGE
II	(Continued)	
	Efforts for the Control of Cancer	22
	Measures of National and International Importance	22
	The Massachusetts State Cancer Program	23
III	SOCIAL CHARACTERISTICS OF THE PATIENTS STUDIED	25
	Age	25
	Sex	27
	Nationality	28
	Personal Status	29
	Vocations	30
IV	CLINICAL ANALYSIS OF THE TOTAL GROUP OF PATIENTS	32
	Diagnoses	32
	Impressions	35
	Patients' Status in Tumor Clinic	38
	Patients Who Received Treatment Elsewhere	44
	Classification of Patients' Treatment	45
	Reasons for Discharges	47
	Social Services to Patients	50





## TABLE OF CONTENTS

CHAPTER	<u>LIST OF TABLES</u>	PAGE
V	CASE ILLUSTRATIONS	51
VI	SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS	68
APPENDICES	AND SEX DISTRIBUTIONS OF PATIENTS	75
BIBLIOGRAPHY	QUALITY AND SEX DISTRIBUTION	83

III. PERSONAL STATUS OF PATIENTS . . . . .

IV. OCCUPATIONAL CLASSIFICATION AND SEX DISTRIBUTION OF PATIENTS . . . . .

V. CLASSIFICATION OF PATIENTS BY RACE AND SEX DISTRIBUTION . . . . .

VI. CLASSIFICATION OF PATIENTS BY AGE AND SEX DISTRIBUTION . . . . .

VII. PATIENTS' STATUS IN THE HOME . . . . .

VIII. PATIENTS WHO WERE HOSPITALIZED, ADMITTED, AND WERE THE PATIENTS WHO WERE ADMITTED AFTER DISCHARGE . . . . .

IX. RELATIVE PAYMENTS AND THE STATUS OF PATIENTS . . . . .

X. PATIENTS WHO WERE ADMITTED FOR THE FIRST TIME . . . . .

XI. PATIENTS WHO WERE ADMITTED FOR THE SECOND TIME AND WERE ADMITTED IN 1917 . . . . .

XII. LIST OF PATIENTS WHO WERE ADMITTED . . . . .

XIII. SUMMARY OF FINDINGS . . . . .





# LIST OF TABLES

<u>TABLES</u>	<u>PAGE</u>
I. AGE AND SEX DISTRIBUTION OF PATIENTS . . .	25
II. NATIONALITY AND SEX DISTRIBUTION . . . . .	28
III. PERSONAL STATUS OF PATIENTS . . . . .	29
IV. VOCATIONAL CLASSIFICATION AND SEX DISTRIBUTION OF PATIENTS . . . . .	31
V. CLASSIFICATION OF PATIENTS' DIAGNOSES AND SEX DISTRIBUTION . . . . .	34
VI. CLASSIFICATION OF PATIENTS' IMPRESSIONS AND SEX DISTRIBUTION . . . . .	37
VII. PATIENTS' STATUS IN THE TUMOR CLINIC . . .	38
VIII. PATIENTS WHO WERE HOSPITALIZED ELSEWHERE AND WHERE THE PATIENTS WERE FOLLOWED AFTER DISCHARGE . . . . .	40
IX. REASONS PATIENTS REFUSED HOSPITALIZATION .	41
X. PATIENTS' REASONS FOR NOT RETURNING . . .	42
XI. PATIENTS WHO RECEIVED TREATMENT ELSEWHERE AND STILL FOLLOWED IN CLINIC. . . . .	44
XII. EXTENT OF PATIENTS' TREATMENT . . . . .	46
XIII. REASONS FOR DISCHARGES AND SEX DISTRIBUTION . . . . .	49





## CHAPTER I

### INTRODUCTION

#### Purpose of Study

Within the last few years a definite effort has been made by the medical profession to educate the public to the importance of early medical care and regular follow-up of all patients with tumors and suspected cancer.

The Massachusetts Memorial Hospitals' Social Service Department for some time has been interested in the large number of patients who have failed to keep appointments in the tumor clinic. It was felt that a study of a group of non-returning patients would be of value to the clinic. In this thesis an attempt has been made by the writer to answer the following questions:

1. What is the composition of the clinic's patient group studied?
2. In terms of the total group studied, to what extent did they receive treatment for their original complaint?
3. What was the proportion who failed to return?
4. What were their reasons for failing to return?
5. What per cent of the patients were receiving treatment elsewhere, but still being followed in the clinic?
6. What changes could be recommended to decrease the number of delinquent patients?





In attempting to answer the above questions, the writer intended that the study would provide a description of the over-all purpose and function of the clinic, a description of the patients in the group studied, the clinical status of the group of patients studied, and an analysis of the delinquency group. It is necessary to know the present state of scientific knowledge in regard to tumors, and the result of certain types, namely cancer. It is also essential to consider the Massachusetts State Cancer Program, in view of the fact that this program centers around preventive work.

#### Scope of Study

This study includes all of the patients admitted to the Massachusetts Memorial Hospitals Tumor Clinic over a six months period. The time period covered, expressed in dates on which the clinic met, was January 3, 1947 through June 27, 1947. In selecting this six month period, consideration was given to the need for studying a group admitted recently enough in order not to have a high mortality rate. It was also considered that this group would present a more adequate picture of current problems of tumor clinic patients. During the period covered, fifty-seven patients were admitted to the clinic.

#### Method of Gathering Data

A separate schedule on each patient was filled out





from material obtained from the tumor clinic, hospital, and outpatient department medical records, social service records, and clinical files. Pertinent material which could not be found in the clinic records was supplied verbally by the current clinic social worker and the clinic secretary. Nine personal interviews in the patients' homes, two telephone calls, two visits to a private doctor's office were made in respect to the patients who failed to return. In one case, it was impossible to find the patient at home, and the data was secured from her married daughter.

An interview was arranged with one of the clinic doctors to gain information about the purpose, function and organization of the tumor clinic.

A study was conducted by the tumor clinic social worker on all the non-returning patients of 1947 after this thesis was in progress. Some of the data from her questionnaire were incorporated by the writer of this study. A copy of this questionnaire used by the clinic can be found in the Appendix of this thesis.

A review was made of the medical and social literature on the subject of tumors.

#### Limitations of Study

The extent of the material collected for the study was somewhat limited due to the fact that the amount of material contained in the records was restricted because of







the very recent filling of the new position of case worker. Her position was that of case worker in the tumor clinic, as well as being the worker doing case work for the thoracic clinic and covering the social service of the hospital.

Each patient studied was seen upon admission by the clinic social worker as a part of the clinic routine but was not made a social service case. The only patients receiving the case worker's services were those referred specifically by the doctors to the case workers for extensive case work or such services as arrangement for terminal care, interpretation to the patient, his family, or other community agencies.

In the majority of instances, social recording on the cases studied was limited to notes on the clinic social service cards and to notes on the medical face sheets. The tumor clinic medical records are kept separate from the other outpatient records. In many of the cases, the clinical or tentative diagnoses or impressions were all that were indicated. A pathology report was not available on every patient. In some cases, the recommendations which were carried out were not always clearly stated.

A study was started after this one by the tumor clinic social worker on all the patients in 1947 who failed to keep their appointments. A questionnaire was sent to all these patients by the clinic social worker. Some of the





patients in this group the writer is studying were included in the clinic social worker's study. After receiving the questionnaires, several of the patients have returned to the clinic. The writer of this study has limited the period studied to include from January 3, 1947 to January 30, 1948.

The clinical status of the patients has not remained static. On the contrary, the questionnaire sent to them by the clinic social worker has stimulated a large per cent to return. The element of time made it impossible for the writer to include any change in the patients' clinic status after January 30, 1948.

#### Purpose and Organization of Clinic

The tumor clinic of the Massachusetts Memorial Hospitals was started in 1935 for the purpose of study, diagnosis and treatment of tumors. In general, this includes all types of tumors, except brain tumors, as there is not a neurosurgeon on the staff of the clinic. Such a patient would be referred for surgery to another doctor, but would be followed in the clinic. Prior to the establishment of the clinic, tumor patients were formerly treated in various other outpatient clinics of the hospital.

During the period included in this study, the tumor clinic functioned apart from the outpatient department. Since February 6, 1948, the tumor clinic has been





operating in conjunction with the outpatient department of the hospital. At this date, it moved to the outpatient building which was formerly situated in the hospital.

Every effort is made to have clinic patients hospitalized in the Massachusetts Memorial Hospitals when hospitalization is indicated. Practically no surgery is done in the surgical ambulatory clinic except an occasional biopsy or minor operation. The clinic has its own facilities for minor biopsy. The X-ray department is opposite the tumor clinic and physically and cooperatively they worked together. All radium treatment is done in the hospital and requires that the patient be hospitalized.

During the period covered in this study there was a chief physician present in the clinic. There were seven attending physicians, four of whom attended regularly. A nurse, case worker, clinic secretary and a volunteer were all present at the weekly meetings of the clinic.

Last year the clinic was given a grant by the American Cancer Society. The doctors on the staff give their services, as is the practice in most clinics. Two of the men were paid salaries by the American Cancer Society.

There is at present a dollar and fifty cent clinic fee for patients. This is not rigid. It is altered according to the patient's ability to pay. This practice went into effect in June, 1947. This year (1948) the clinic has







been given a grant by the United States Public Health Department.

### Importance of Study

"The symbol of the American Cancer Society's 1947 Campaign emphasizes the fact that one in eight will die of cancer unless we act."<sup>1</sup> The rate, one in eight means in very broad statistical terms that: "It is inescapable, numerically that cancer will claim a victim in one out of every two average American families."<sup>2</sup>

All the patients known to the tumor clinic at the Massachusetts Memorial Hospitals were referred either by another clinic in the hospital, by a private physician, by recommendations of friends or came because of the reputation of the clinic.

All these patients had to start with some symptom or symptoms that brought them to the clinic. Any of these symptoms demand medical attention or expert medical advice. Early recognition and adequate treatment of these symptoms is one of the primary purposes of this clinic, or any tumor clinic. The value to be derived by the patients from keeping their appointments regularly and being faithful to their

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1

American Cancer Society, Campaign Speaker's Handbook, 1947, p. 3.

2

Ibid., p. 3.





treatment, cannot be over-emphasized.

**MEDICAL** The statistical evidence above supports the importance of the questions this study hopes to answer. The explanation or reasons for the delinquency in the clinic among the group of patients will be revealed and may be of help in decreasing the number of non-returning patients in the future.

### Benign Tumors

A benign tumor is a local overgrowth of abnormal cells forming a distinct mass which has no special properties. A benign tumor is not capable of transgressing the blood to other parts of the body. "It enlarges by compressing, simply pushing aside the tissues as it grows." Some of the more common examples of benign tumors are warts, moles, warts, fatty tumors, fibroid tumors, cysts, etc. If a benign growth is small, it may not cause much trouble, but on the surface of the body it often grows rapidly, and is removed for cosmetic purposes. If a tumor grows to

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1 Massachusetts Department of Public Health,  
State and Local Health Officers, Sixth Edition, p. 10.

2 Albert S. Morrow, M.D., Diagnosis & Treatment for High School Teachers, p. 17.

3 Ibid., p. 17.





## CHAPTER II

## MEDICAL INFORMATION ON BENIGN AND MALIGNANT TUMORS

Definition of a Tumor

A tumor is a growth of tissue that has no useful function. Tumors, or neoplasms as they are technically called are divided into two classes: benign, or harmless tumors, and malignant tumors, or cancers. "Every cancer is a tumor, but all tumors are not cancers."<sup>1</sup>

Benign Tumors

"A benign tumor is a local overgrowth of abnormal cells forming a distinct mass which has no useful purpose."<sup>2</sup> A benign tumor is not capable of transporting its tissue to other parts of the body. "It enlarges by expansion, simply pushing aside the tissues as it grows."<sup>3</sup> Some of the more common examples of benign tumors are corns, wens, warts, fatty tumors, fibroid tumors, cysts, etc. If a benign growth is small, it may not cause much inconvenience. On the surface of the body it often proves unsightly, and is removed for cosmetic purposes. If a benign growth is

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<sup>1</sup>

Massachusetts Department of Public Health,  
Whats and Whys of Cancer, Sixth Edition, p. 3.

<sup>2</sup>

Albert S. Morrow, M.D., Cancer. A Manual for  
High School Teachers, p. 17.

<sup>3</sup>

Ibid., p. 17.





deeply situated, inside of the body, it may cause pressure on nearby organs, thus interfering with the normal bodily function. This type of growth frequently requires removal.

### Malignant Tumors

"Malignant tumors, or cancers, are lawless overgrowths of body cells which do not remain localized, as benign do, but spread to other parts of the body."<sup>4</sup> The danger of cancer is that it does not stop growing. It not only infiltrates between normal cells but it destroys them.

Cancer spreads in three ways:

(1) locally, by direct extension of the growth in the tissues in which it originates, (2) by dissemination of cancer cells by means of the lymph and blood streams . . . This dissemination of malignant cells is known as metastasis. The rapidity with which a tumor metastasizes varies according to the type of its cells, the location of the tumor and the amount of injury to which it is subjected. Metastasis does not take place in all malignant growths . . . (3) by transplantation of cancer cells to other structures.<sup>5</sup>

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4

Morrow, op. cit., p. 18.

5

Ibid., pp. 18-19.





## The Present State of Medical Science in Regard to Cancer as a Disease

Cancer is a growth of tissue, usually ulcerating, tending to spread by local infection and also through the lymph and blood stream, associated with general ill health and progressive emaciation; so-called originally because the veins and hardened tissue extending from it compared by the ancients to the claws of a crab.<sup>6</sup>

A cancerous growth is a malignant tumor. "The laws that control growth are broken and the function of normal tissue is not present."<sup>7</sup>

## Geographical Differences in Cancer Incidence

It is interesting to note geographical differences in the incidence of certain forms of cancer. In Massachusetts deaths from skin cancer are less prevalent than in Georgia. In Japan breast cancer is a rare condition, while in northern United States it is a common condition. In English women the number of deaths from cancer of the breast exceed those of cancer of the stomach, a condition not found in any other nation. In Java the most common type of cancer is primary cancer of the liver, a relatively rare condition in the United States. In French Indo-China cancer of the stomach and intestinal tract is responsible for about 5 per cent of all cancer deaths; in Massachusetts for almost 50 per cent. Switzerland has an exceptionally high incidence of cancer of the esophagus in males, while in Swiss women it is rare.<sup>8</sup>

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6

George W. Holmes, M.D. and others, Cancer. A Manual for Practitioners, p. 1.

7

The Committee on Publication, Cancer Control. The What - Whither - How, p. 49.

<sup>8</sup>Ibid., p. 49.





### Prevention of Cancer

The prevention of cancer is not merely a question of life or death to the millions of people in the world today. It means a great deal more. Death has no great terror for men and women of common sense and intelligence. We all must die. Many individuals can be spared the torture of death from cancer by taking certain preventive measures.

"Of the greatest importance is the diagnosis of the actual disease at such an early stage that the disease can be completely eradicated by proper treatment."<sup>9</sup> Cancers often grow in locations in which the tissues are not healthy. The removal of such tissue is of utmost importance. There are certain conditions which, if not treated, may progress and form a cancer in later life. The elimination of chronic irritation and the removal of unhealthy tissue will prevent many cancers. Probably one of the best preventive measures is the periodic health examination especially when one is beyond the age of thirty-five. A discussion with a physician of the habits of the individual may bring out items which should be corrected.





James Ewing has formulated certain basic recommendations for the prevention of cancer:

1. Preparation and wide dissemination of short concise popular treatise on the prevention of cancer.
2. Inculcation of the importance of habits of moderation in eating, drinking, exercise and exposure to all forms of irritation.
3. Compulsory protection of workers in all industries which carry a specific cancer hazard and instruction of all workers in such industries regarding these hazards.
4. Systematic publicity in news and other publications regarding frequency, mode of origin and means of insurance against cancer.
5. Consistent emphasis on the importance of bodily cleanliness as a preventive of cancer.<sup>10</sup>

### The Causes

At present the etiology of the disease is still in the research stage. At the writing of this study, science is ignorant of the specific cause or causes of cancer. There are certain factors frequently found associated with the development of malignant growths. In some of the literature, they are referred to as predisposing causes.

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10

George T. Pack and Edward M. Livingston, Editors, Treatment of Cancer and Allied Diseases, p. 13.





Degenerative changes of old age, chronic inflammatory conditions, or repeated injury or irritation predispose to cancer by producing cellular changes in the tissues which seem to furnish the soil favoring abnormal growth. These cellular changes, as well as certain other pathological conditions, are frequently spoken of as "precancerous conditions" because, while not actually cancers, they often become so if not corrected. Common precancerous conditions are warts and moles, especially the very dark colored or pigmented moles; dry scaly patches on the skin, called keratoses; white patches (leukoplakia) which appear on the tongue and mucous membrane of the mouth; persistent sores, erosions, or ulcers; unrepaired injuries to the uterus as the result of child-birth, etc.<sup>11</sup>

Another important predisposing cause is age.

Cancer may occur at any age, though it is more common in middle and late life. There is no particular age, sex, color, creed, social or economic class that is safe.

At a period in our history when most of our economic and social trends are in the direction of race, class, group or creed consciousness, it may prove to be a God-send that there is the need for united action against a common menace.<sup>12</sup>

Repeated injury or chronic irritation of tissue is recognized to be a predisposing cause of many cancers.

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<sup>11</sup>

Albert S. Morrow. op. cit. p. 23.

<sup>12</sup>

C.C. Little, The Social Significance of Cancer, p. 244.





"A single injury, however, is rarely a factor in producing carcinoma."<sup>13</sup> Some cases of sarcoma may result from a single injury. "In many cases, there seems to be a direct connection between a single injury and bone sarcoma."<sup>14</sup> The literature reveals that mechanical, thermal, and chemical irritation are capable of producing cancer. "Exposure to actinic rays, roentgen rays, and radium are all capable of producing cancer when their effects are felt by the tissues over too long a period."<sup>15</sup>

Various studies have been made on the relativity of heredity to cancer.

Deelman found twice as many cancers among the parents of cancer patients as among the parents of non-cancer individuals, and three times as many cancers among the brothers and sisters of cancer patients as among the brothers and sisters of non-cancer patients. However, the excess was limited to a very few families.<sup>16</sup>

There is considerable literature that bears evidence that in animals hereditary constitution has a bearing on cancer growth.

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<sup>13</sup>

Albert S. Morrow. op. cit., p. 25.

<sup>14</sup>

Ibid., p. 25.

<sup>15</sup>

Ibid., p. 25.

<sup>16</sup>

The Committee on Publication, op. cit., p. 52.





The general opinion prevails that in certain strains of mice there is an increased susceptibility and a diminished resistance to the development of cancer. This may be altered by nursing the litter on a female of different genetic constitution. Studies of neoplasms arising in identical twins who present the same heredity pattern as reported by Mc Farland, Meade, Militzer and others, serve to illustrate this point.<sup>17</sup>

The Massachusetts Department of Public Health states:

The chances of an individual, one of whose parents had cancer, of developing cancer is about the same as that of an individual without a cancer parent. Members of families in which cancer has occurred should be particularly careful to avoid chronic irritation, but the same advice may well be given to members of families in which no cancer has occurred.<sup>18</sup>

This issue of the relativity of heredity to cancer remains a controversial one in the field of cancer research.

The current literature gives no indication that cancer is contagious. It is not a communicable disease.

#### Symptoms

Cancer is a disease which gives very few early symptoms, yet requires early diagnosis if it is to be cured.

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17

George W. Holmes, op. cit., p. 57.

18

Massachusetts Department of Public Health, op. cit., pp. 4-5.





Most tumors have an insidious onset. The symptomatology of cancer varies with its location. Tumors situated superficially are discovered earlier than those which are deep-seated.

Because they are obvious, the early diagnosis of superficial tumors is the reason why their therapy is so relatively satisfactory. The diagnosis of a deep-seated tumor is now difficult because symptoms are essential before the patient suspects that something is wrong and often by that time the tumor is of long standing.<sup>19</sup>

Pain is not an early symptom of the disease.

"Pain from cancer is usually a late symptom except in some malignant bone tumors."<sup>20</sup> "Pain, loss of weight and strength characterize the symptoms of the advanced disease."<sup>21</sup>

Physicians urge their patients to consult them as soon as some condition is noticed which was not present before, because the disease is so indefinite in its early stages.

Cancer can develop at any time. One of the purposes of the American Cancer Society is education of the general public. The Society urges all to keep in

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<sup>19</sup>

George W. Holmes, op. cit., p. 51.

<sup>20</sup>

Albert S. Morrow, op. cit., p. 31.

<sup>21</sup>

The Committee on Publications, op. cit., p. 73.

The American Cancer Society, Cancer Can Be Beat, p. 7.





mind the symptoms listed below. If one or more of these symptoms develop, the individual should go at once to a physician for a thorough examination.

1. Any persistent lump or thickening, especially in the breast.
2. Any irregular bleeding or discharge from any of the body openings.
3. Any sore that does not heal, particularly about the tongue, mouth or lips.
4. Persistent indigestion
5. Persistent hoarseness
6. Sudden changes in the form or growth of a mole or wart.
7. Any change in bowel habits.<sup>22</sup>

### Diagnosis

There are no great problems in the diagnosing of cancers involving portions of the body which can be exposed to view. Cancers involving internal organs belong in a different category and to recognize these a painstaking examination is often necessary. The diagnosis of cancer may be divided into two parts. One is the tentative or clinical diagnosis; the other is the positive diagnosis determined by microscopic examination of suspected tissue.





"For a positive pre-operative diagnosis as to whether a tumor is malignant, a piece of tissue must be removed and submitted to microscopic examination."<sup>23</sup> The removal of tissue for examination is called a biopsy. Aspiration biopsy is another method used to obtain specimens of tissue for microscopic examination.

This consists of inserting a fairly large needle attached to a syringe into the growth and producing strong suction in the syringe as the point of the needle is directed into different portions of the tumor.<sup>24</sup>

Fragments of tissue drawn from the needle are then submitted to microscopic examination. By means of microscopic examination, the pathologist is able to determine whether a tumor is benign or malignant, and frequently can determine the grade of malignancy. "Good preventive medicine involves the careful diagnosis and evaluation of all tumors."<sup>25</sup>

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23

Albert S. Morrow, op. cit., p. 52.

24

Ibid., p. 52.

25

George W. Holmes, op. cit., p. 55.





### Treatment

"Surgery, X-Ray, and radium are at present the only three accepted treatments for curing cancer."<sup>26</sup>

"There is no essential difference between the action of X-Ray and radium."<sup>27</sup> The physician uses one, two, or all three of the above-mentioned methods. Each cancer patient must be treated as an individual problem. The amount and type of treatment needed will depend upon the location, type and site of the cancer, its duration, its role of growth and other factors.

The American Cancer Society have a slogan "Witch Doctors Can't Cure Cancer!" and have published a pamphlet under the same title.

There is no salve, ointment, radium water, mineral water, liquid medicine, pill, Indian Charm, or needle injection treatment that has ever cured a case of proved internal cancer. Cancer quacks and charlatans in many parts of the country are being prosecuted and disbarred from practice. There is no system of faith healing or religion or electrical treatments or systems of baths, sweat boxes, or ice boxes that has definitely cured proved cancer.<sup>28</sup>

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<sup>26</sup>

Public Affairs Committee, Facing the Facts About Cancer, p. 19.

<sup>27</sup>

The American Cancer Society, Who, What, Why, When, Where of Cancer, p. 13.

<sup>28</sup>

The American Cancer Society, Witch Doctors Don't Cure! p. 1.





It is well to remember that cancer is a personal problem and although many stand by ready to help a patient meet and solve that problem, their own initiative and early action must be the first step towards hopeful and successful treatment. "Cancer is a local disease at the start. If taken in time, there is no question of the curability of many cancers."<sup>29</sup>

### World-Wide Problem

Cancer is a world-wide problem. It is a universal disease affecting all races of mankind.

Cancer is today the second most important cause of death, exceeded only by the diseases of the heart. Cancer is now responsible for twelve per cent of all deaths in the United States.<sup>30</sup>

All ages and both sexes are susceptible to this disease and it does not respect childhood. Morrow states that it takes its toll among the young. Leukemia, a cancer of the blood cells and blood forming organs, is not too uncommon a form of disease among children. Many more school-age children die each year from cancer than from infantile paralysis; in fact, more than from any two of the communicable diseases of childhood combined.<sup>31</sup>

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<sup>29</sup>

Albert S. Morrow, op. cit., p. 54

<sup>30</sup>

Louis I. Dublin, Ph.D., "The Latest on Cancer," Woman's Home Companion. March 1947, p. 28.

<sup>31</sup>

Ibid., p. 28.





## Efforts for the Control of Cancer

### Measures for National and International Importance

The present era, unprecedented in its history, is characterized by marked concentration on the subject of cancer. Research, special cancer hospitals and clinics are now established in this country and in many countries throughout the world. "Cancer is a problem of every small community. It is also international in its aspects."<sup>32</sup> The United States Public Health Service is at work on the problem.

Congress recognized the need for basic and fundamental research in this field and, in 1937, established the National Cancer Institute within the United States Public Health Service.<sup>33</sup>

The National Cancer Institute works within the United States Public Health Service.

Individual states are developing valuable cancer programs. "The American Cancer Society has conducted educational campaigns since 1913."<sup>34</sup> The American Cancer Society is doing a good job in the awakening of "cancer consciousness" in the general public, and educating them in the curability of early cancer. There are many other organizations that give most generously of their time and money in the cancer cause.

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<sup>32</sup>

George W. Holmes, op. cit., p. 63.

<sup>33</sup>

Public Affairs Committee, op. cit., p. 28.

<sup>34</sup>

George W. Holmes, op. cit., p. 63.





There is the Damon Runyon Cancer Fund that solicits contributions mainly by radio, and turns them over to established cancer research institutions to spend. And there is the Donner Foundation in Philadelphia, the Jane Coffin Childs Memorial Fund for Medical Research at Yale University, the Anna Fuller Fund in New Haven, and many others. There are also research projects in connection with most universities and medical schools such as the University of Minnesota, the University of California, the University of Iowa, the University of Chicago, the University of Washington, and the University of Wisconsin. Some are financed by national organizations, and others locally.<sup>35</sup>

Many other countries are engaged in research on the problem. "There is an international group, the Union Internationale contre le Cancer, which holds meetings at intervals of several years."<sup>36</sup>

#### Massachusetts State Cancer Program

"Massachusetts is a pioneer state in cancer control."<sup>37</sup> The Commissioner of Public Health, Dr. Vlado A. Getting, stated in a lecture on February 24, 1948 to the students of the Community Organization for Health Needs class at the Boston University School of Social Work that

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<sup>35</sup>

Public Affairs Committee, op. cit., p. 29.

<sup>36</sup>

Ibid., p. 30.

<sup>37</sup>

Frances A. MacDonald, "Evaluation of Cancer Control Methodology," American Journal of Public Health, 30:492, May 1940.





"the State cancer program in Massachusetts is a unique one and one to be proud of." It is now under the direction of Dr. Herbert L. Lombard, Director of the Division of Cancer and other Chronic Diseases.

The Massachusetts State Cancer Program is principally a preventive and diagnostic program. "The Massachusetts Cancer Program has been shown by a statistical appraisal to be effective in the problem of cancer control."<sup>38</sup> It contains all the activities that are considered necessary for a well-integrated program. "The Massachusetts Cancer Program is composed of five parts: hospitalization; diagnostic clinics; tumor diagnostic service; research; and education."<sup>39</sup>

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<sup>38</sup>

The Committee on Publications, op. cit., p. 8.

<sup>39</sup>

Ibid., p. 10.





## CHAPTER III

## SOCIAL CHARACTERISTICS OF THE PATIENTS STUDIED

Age

Table I illustrates the age and sex distribution of the fifty-seven patients studied. These patients ranged in age all the way from two three-month-old babies to a ninety-year old man.

TABLE I

## AGE AND SEX DISTRIBUTION OF PATIENTS

Age	Total	Male	Female
Total	57	17	40
Under 15 years	3	2	1
15 through 24	7	2	5
25 through 34	3	1	2
35 through 44	12	-	12
45 through 54	8	3	5
55 through 64	10	3	7
65 through 74	9	2	7
75 through 84	4	3	1
Over 85 years	1	1	-

Metropolitan Life Insurance Company. There Is  
Something You Can Do About Cancer, p. 6.





Malignant tumors are primarily a disease of middle and late life. Therefore, it was not surprising to note that the bulk of the patients (seventy-seven per cent) included in this study were thirty-five years and over. Almost half (forty-nine per cent) of the patients were between thirty-five and sixty-four years of age. The largest single group (twenty-one per cent) was between thirty-five and forty-four years of age. Middle-aged and elderly people are considered to be in the greatest danger of cancer.<sup>1</sup> However, this study revealed that the largest single group of patients fell into younger middle-aged classification--those between the ages of thirty-five and forty-four. There were thirteen patients (twenty-three per cent) in the total group studied who were under thirty-five years of age. Four of them were adolescents and one was in the pre-school stage. It was interesting to note that there were two very young patients, two three-month-old babies, one male and one female.

Because of the limited scope of the study, it would be impossible to draw any specific conclusions regarding the medical implications of the age group and sex distribution of the patients.

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Metropolitan Life Insurance Company, There Is Something You Can Do About Cancer, p. 6.





### Sex

Some of the literature in the field states that cancer affects more females than males. "In communities where cancer detection centers have been established, women have gone to them for examination at the rate of three to one over men."<sup>2</sup> Others have stated that it affects both sexes alike. This study of six months' admissions to the Massachusetts Memorial Hospitals Tumor Clinic gives some evidence to support the former theory. However, it must be remembered throughout this thesis that the fifty-seven patients being considered did not have cancer per se, but all of them did have some type of a tumor. This is explained more fully in Chapter IV.

It is shown in Table I that of the total group of patients being considered, seventeen (thirty per cent) were males and forty (seventy per cent) were females. This indicates a very uneven sex distribution within the group. It was significant to note in Table I that the largest single group between the ages of thirty-five and forty-four was entirely made up of females. "Cancer kills more women between thirty and fifty-four years of age than any other disease. . . ."<sup>3</sup>

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<sup>2</sup>

American Cancer Society, Campaign Speaker's Handbook, 1947, p. 11.

<sup>3</sup>

Ibid., p. 18.





### Nationality

A total of nine different nationality groups were represented in the group of patients studied. Over one-half of the patients (sixty-one per cent) were American born. The second largest groups were the Canadian and Irish, making up fourteen and seven per cent respectively, of the total group. The remaining, comprising Italian, English, German, Russian, Polish and Austrian, constituted eighteen per cent. (See Table II)

TABLE II

#### NATIONALITY AND SEX DISTRIBUTION OF PATIENTS

Nationality	Total	Male	Female
Total	57	17	40
American	35	10	25
Canadian	8	1	7
Irish	4	2	2
Italian	3	2	1
English	2	-	2
German	2	1	1
Russian	1	1	-
Polish	1	-	1
Austrian	1	-	1





The tumor clinic draws a large proportion of its patients from referral by private doctors. It has been indicated that the foreign-born do not go to private physicians as much as they do to clinics. The fact that many of the patients were referred by private doctors may account to some extent for the large number of thirty-five (sixty-two per cent) of the patients being American-born.

#### Personal Status

As is illustrated in Table III, three-fifths (sixty per cent) of the patients were married at the time of admission to the tumor clinic. The second largest group were single, comprising twenty-three per cent of the total. This group included four adolescents, a three year old child, and two three-month-old babies. Sixteen per cent of the group were widowed. The remaining one per cent was divorced.

TABLE III

#### PERSONAL STATUS OF PATIENTS

Personal Status	Number
Total	57
Married	34
Single	13
Widowed	9
Divorced	1





### Vocations

The vocations of the patients were varied though the greatest percentage of the total group was concentrated mainly in the domestic and personal group. This group made up sixty-seven per cent. The next largest were the manual and mechanical group, making fourteen per cent of the total. The clerical and pre-school groups each made up seven per cent. The remaining five per cent constituted the clergy and trade groups. (See Table IV)

Trade

(Retail and Wholesale)

Clergy

Housewife, housekeeper, unemployed, retired,  
Old Age Assistance recipients.

Self-employed operator, laborer, mechanical  
designer, mechanic, track-helper, carpenter.

Secretary, book-keeper, bill collector.

Salesman, barber.





TABLE IV

VOCATIONAL CLASSIFICATION AND SEX  
DISTRIBUTION OF PATIENTS

Vocation	Total	Male	Female
Total	57	17	40
Domestic and Personal <sup>a</sup>	38	4	34
Manual and Mechanical <sup>b</sup>	8	7	1
Clerical <sup>c</sup>	4	-	4
Pre-school and School	4	3	1
Trade (Retail and Wholesale) <sup>d</sup>	2	2	-
Clergy	1	1	-

<sup>a</sup> Housewife, housekeeper, unemployed, retired, Old Age Assistance recipients.

<sup>b</sup> Switchboard operator, laborer, mechanical designer, mechanic, truck-helper, carpenter.

<sup>c</sup> Secretary, bank messenger, billing clerk.

<sup>d</sup> Salesman, baker.





## CHAPTER IV

## CLINICAL ANALYSIS OF THE TOTAL GROUP OF PATIENTS

Diagnoses

The diagnoses and impressions of the fifty-seven patients studied were grouped according to the body systems of the sites of their tumors. It was found that not all diagnoses were positive diagnoses, (meaning that not all were determined by microscopic examination.) Included among these are some tentative or clinical diagnoses. Among the thirty-four patients studied, twelve patients (twenty-one per cent) had positive diagnoses of malignant tumors.

The classifications of the body systems in Table V and Table VI are not on the basis of purely anatomical or purely functional criteria. The classification is a combination of both.

Thirty-four patients or sixty per cent of the total group studied had a diagnosis made either before admission to the clinic or after one, two, or three visits. Fifteen per cent were made before the patients were admitted to the clinic, seventy-six per cent were made on the first visit, and three per cent and six per cent respectively were made on the second and third visits made by the patients to the clinic.





Ackerman and del Regato<sup>1</sup> have reported that carcinoma of the skin is, without dispute, the most common form of cancer. This study supports the statement of the above-mentioned doctors. Table V illustrates that of the thirty-four patients with diagnoses, ten were under the classification of the protective system. This is the largest single group of those patients with diagnoses. In this specific group, five (fifty per cent) of the patients had definite diagnoses of carcinoma. Eight of the patients (eighty per cent) classified under the protective system were males. "Men are more frequently subject to cancer of the skin perhaps because a greater number work out of doors."<sup>2</sup>

Doland<sup>3</sup> found that breast cancer is one of the most common types of cancer found in women. The literature in the field was in accord with this fact. "It is known that many women with cancer of the breast have some degree of chronic cystic mastitis in the same breast."<sup>4</sup> The second largest single group had diagnoses classified in the urogenital system. (See Table V)

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<sup>1</sup> Lauren V. Ackerman, M.D., and Jaun A. del Regato, M.D., Cancer, Diagnosis, Treatment and Prognosis, p. 126.

<sup>2</sup> Ibid., p. 134-

<sup>3</sup> George W. Holmes, M.D., Cancer. A Manual For Practitioners, p. 132.

<sup>4</sup> Ibid., p. 133.





TABLE V

CLASSIFICATION OF PATIENTS DIAGNOSES  
AND SEX DISTRIBUTION

Body System	Total	Male	Female
Total	34	12	22
Cardiovascular <sup>a</sup>	5	1	4
Digestive <sup>b</sup>	3	1	2
Hormonal Regulatory <sup>c</sup>	3	-	3
Locomotor <sup>d</sup>	1	-	1
Nervous <sup>e</sup>	1	1	-
Urogenital <sup>f</sup>	7	-	7
Protective <sup>g</sup>	10	8	2
Repair <sup>h</sup>	2	1	1
Respiratory <sup>i</sup>	1	-	1
Storage <sup>j</sup>	1	-	1

<sup>a</sup>Heart, arteries, veins, lymphatics<sup>b</sup>Gastrointestinal tract, liver, pancreas, etc.<sup>c</sup>Endocrine glands<sup>d</sup>Skeletal muscle<sup>e</sup>Central nervous system, peripheral nerves, autonomic<sup>f</sup>Reproductive system (including breasts) and urinary system<sup>g</sup>Skin, lymphnodes, tissue phagocytes, white blood cells<sup>h</sup>Connective tissue, bone marrow repairing of blood cells<sup>i</sup>Lungs<sup>j</sup>Fat, liver (partly)





This entire group, seven patients, consisted of females. Three had definite diagnoses of carcinoma of the breast, and one in the group being considered had a definite diagnosis of epidermoid carcinoma of the cervix. The three remaining patients had tumors involving the breast, two with diagnoses of chronic cystic mastitis, and the third had a fibroma of the left breast. "In Massachusetts the death rate for women exceeds that for men. This is due to the large number of women who die from cancer of the breast and cancer of the womb."<sup>5</sup>

#### Impressions

Twenty-three of the patients (forty per cent) under consideration in this study had only impressions on their clinic medical records. This is explainable by the fact that a large proportion of the patients failed to return to the clinic after the first or the first few visits. They were either terminated by the patient's hospitalization or by the patients themselves. (This is explained in more detail later in this chapter). Eighty-seven per cent of the impressions were made on the patient's first visit to the tumor clinic, four per cent and nine per cent were made respectively on this group's first and

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The Committee on Publication, Cancer Control.  
The What, Whither, How, p. 33.





second visits. The classification of the impressions are set out in Table VI.

Body System	Total	Male	Female
Total	24	5	19
Frame Work <sup>a</sup>	1	1	-
Hormonal Regulatory <sup>b</sup>	2	-	2
Nervous and Psychogenic <sup>c</sup>	2	1	1
Urogenital <sup>d</sup>	10	1	9
Protective <sup>e</sup>	3	-	3
Repair <sup>f</sup>	2	1	1
Storage <sup>g</sup>	3	1	2

<sup>a</sup> Bone and connective tissue

<sup>b</sup> Endocrine glands

<sup>c</sup> Central nervous system, peripheral nerves, autonomic

<sup>d</sup> Reproductive system (including breast) and urinary system

<sup>e</sup> Skin, lymph nodes, tissue phagocytes, white blood cells

<sup>f</sup> Connective tissue, bone marrow repaired or blood cells

<sup>g</sup> Fat (liver partly)





TABLE VI

CLASSIFICATION OF PATIENTS IMPRESSIONS  
AND SEX DISTRIBUTION

Body System	Total	Male	Female
Total	23	5	18
Frame Work <sup>a</sup>	1	1	-
Hormonal Regulatory <sup>b</sup>	2	-	2
Nervous and Psychogenic <sup>c</sup>	2	1	1
Urogenital <sup>d</sup>	10	1	9
Protective <sup>e</sup>	3	-	3
Repair <sup>f</sup>	2	1	1
Storage <sup>g</sup>	3	1	2

a

Bone and connective tissue

b

Endocrine glands

c

Central nervous system, peripheral nerves,  
autonomic

d

Reproductive system (including breast) and  
urinary system

e

Skin, lymphnodes, tissue phagocytes, white  
blood cells

f

Connective tissue, bone marrow repairing of  
blood cells

g

Fat (liver partly)





Patients' Status in Tumor Clinic

Table VII illustrates the patients' status in the clinic. Three of the patients (five per cent) are classified as preferring private care. These patients required hospitalization and surgery. They were members of the Blue Cross and Blue Shield and were eligible for private care. For this reason, they were taken on by one of the clinic doctors as private patients. The information was obtained from the returns of the clinic questionnaire<sup>6</sup> that two of these patients desired to be seen in the clinic again. They were never discharged from the clinic.

TABLE VII

PATIENTS' STATUS IN THE TUMOR CLINIC

Status of Patient	Total
Total	57
Failed to return for observation or treatment	19
Discharged from clinic	16
Still under observation or treatment	13
Referred to other clinics in hospital	6
Preferring private care	3

<sup>6</sup> See Appendix C and D.





Six of the patients (eleven per cent) were referred to other clinics in the hospital. All but one of these patients carried out the recommendations. The patient who failed to carry out the recommendations has responded to the clinic's questionnaire<sup>7</sup> and is being followed again in the tumor clinic. This single group of six patients are still considered tumor clinic patients and have not been discharged from the clinic.

Thirteen patients (twenty-three per cent) have kept their appointments and are still either under treatment or observation in the clinic. Sixteen patients (twenty-eight per cent) were discharged from the clinic. The reasons why this group were discharged from the clinic are set up in Table VIII.

Nineteen of the patients (thirty-three per cent) failed to return for observation or treatment. Included among this group were thirteen patients who were advised that hospitalization was indicated. Table VIII shows the number who followed the recommendations and where the patients were followed after being discharged from the hospital. Table IX shows the patients who refused hospitalization.

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<sup>7</sup>

Ibid.





TABLE VIII

PATIENTS WHO WERE HOSPITALIZED WHO FAILED TO RETURN  
TO THE CLINIC AND WHERE THE PATIENTS WERE FOLLOWED  
AFTER DISCHARGE

Place where patient was followed	Total
Total	8
Surgical Follow-up Clinic	5
Private Physicians	2
Chelsea Naval Hospital	1

When the patients are discharged from the hospital after surgery, they are given a referral slip to the Surgical Follow-Up Clinic. It is interesting to note that five of the patients were followed in this clinic. None of the patients in the group followed in the Surgical Follow-Up Clinic returned to the tumor clinic for a check-up after they were discharged.

The two patients who were followed by private physicians were patients who had Blue Cross and Blue Shield Insurance. These patients have not been discharged from the tumor clinic.

The one patient who was followed at the Chelsea Naval Hospital was not operated on in the Massachusetts





Memorial Hospitals. She was a veteran of the Waves and was eligible for care in a Naval Hospital. She was operated on in the Naval Hospital and followed post-operatively in this hospital and by the private physician who referred her to the tumor clinic. She was never discharged from the tumor clinic.

The reasons patients refused hospitalization are set out in Table IX.

TABLE IX  
REASONS PATIENTS REFUSED HOSPITALIZATION

Attitude	Total
Total	5
Treatment considered useless	1
Fear of surgery	4

It was in a private interview with the referring doctor of the patient classified as treatment considered useless that the writer obtained this information. The patient is seeing the doctor regularly and he gave the information that she has many other complications. Her attitude as he said she has expressed it was that "it's useless to undergo an operation."





Of the four patients classified as fearing surgery, two returned to the private physician who referred them. He stated that the patients feared operations. He could not convince them of the importance of surgery. The remaining two in this group were interviewed in their homes. More information from these interviews and an interpretation of them are included in Chapter V.

A description has been given as to why thirteen of the nineteen patients failed to return to the tumor clinic. The six remaining in this group failed to return for the reasons illustrated in Table X.

TABLE X

## PATIENTS' REASONS FOR NOT RETURNING

Reason	Total
Total	6
Too sick	2
Fear of doctors	1
Not given an appointment	1
Patient died	1
Under care of private physician	1





Two of the patients were too sick to return. Both were elderly people, one male and one female. In both cases the weather was another real factor which kept the patients away from the clinic. One of the patients had never had an experience before with doctors other than to have her children. She had a definite fear of doctors. Another patient, a six-month-old baby, failed to keep her appointment. Her parents were sent one of the clinic's questionnaires<sup>8</sup> and they responded immediately to it by bringing the child in to the clinic. They did not wait to receive a definite appointment. The father stated, "They were told on their last visit to return in six months and the time was not up." This information that the baby was not to return for six months was missing from the patient's medical record. Another reply to another questionnaire<sup>9</sup> supplied the information that the patient, a fifty-nine year old man with a diagnosis of carcinoma of jejunum (small intestine) had died.

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<sup>8</sup>

<sup>8</sup> See Appendix C and D.

<sup>9</sup>

Ibid.





Patients Who Received Treatment Elsewhere

Twenty patients (thirty-five per cent) were being followed in other places and still being followed or considered as clinic patients. This is illustrated in Table XI.

TABLE XI

PATIENTS WHO RECEIVED TREATMENT ELSEWHERE  
AND STILL FOLLOWED IN CLINIC

Place where patient was followed	Total
Total	20
Local Medical Doctor	5
Surgical Follow-Up Clinic*	5
Private Care of Clinic Doctor	3
Medical Clinic*	2
Cardiac Clinic*	1
Gastro-Intestinal Clinic	1
Surgical Outpatient Clinic*	1
Pre-Natal Clinic*	1
Chelsea Naval Hospital	1

\*These are all Clinics in the Outpatient Department  
of the Massachusetts Memorial Hospitals





Only eight (fourteen per cent) of the patients who were treated in other places had the information recorded on their tumor clinic medical records. Three of these patients were patients eligible for private care in the hospital because of their Blue Cross and Blue Shield Insurance. The remaining five were patients who were referred to other clinics in the hospital by the clinic doctors.

Twelve (twenty-one per cent) of the patients 'unknown' to the clinic were known by other clinics in the hospital or under the care of a local doctor. By 'unknown' is meant that, in viewing the patients' written records (social and medical) the information was lacking. However, in communicating with the clinic secretary, she was able to fill in the information verbally in many instances.

Almost three-fourths (seventy-four per cent) of the patients had been known at some time to various outpatient clinics of the hospital.

#### Classification of Patients' Treatment

One of the questions this study hoped to answer is: "In terms of the total group studied, to what extent did they receive treatment for their original complaint?" The classification of the extent of the groups' treatment





set up in Table XII was made in terms of whether the patients kept appointments and followed the recommendations advised by the clinic doctors.

TABLE XII  
EXTENT OF PATIENTS' TREATMENT

Treatment Status	Total
Total	57
Completed treatment	5
Discharged from clinic	11
Still under observation or treatment	19
Partially followed recommendations	12
Preferring private care	3
Completely failed to follow recommendations	7

Five patients (nine per cent) received complete treatment for their original complaint in the tumor clinic. Eleven other patients (nineteen per cent) were also discharged. (See Table XIII). Included among this group was one patient whose condition was too far advanced for treatment and she was discharged without further treatment from the clinic to a nursing home.





Forty-five patients (seventy-nine per cent) have received partial treatment for their original complaint. Included among the forty-five patients who have received partial treatment are nineteen patients (thirty-three per cent) who are still being treated or followed by the tumor clinic. Out of the total group of patients studied, seven patients (twelve per cent) received no treatment and this group failed completely to carry out the recommendations made by the doctors for treatment.

#### Reasons for Discharges

Sixteen patients (twenty-eight per cent) of the patients studied were discharged from the clinic. It is interesting to note that out of the entire group under consideration, only two patients were discharged because of death. From the returns of the clinic's questionnaire<sup>10</sup> the information was secured that one other patient was deceased. The total number of deaths in the group of patients being considered was a remarkably small proportion: three patients (five per cent).

Five of the patients completed treatment and were discharged. Three patients were referred to another hospital or clinics. In this group, one was a baby with an impression of Hodgkins disease. He was treated for a





while in the tumor clinic. The child was discharged to the Children's Hospital in Boston because hospitalization was indicated and the pediatric service at the Massachusetts Memorial Hospitals had closed a few months before. Two of the patients were discharged to clinics in the outpatient department of the hospital. Three patients were discharged because they moved. Two of the patients were husband and wife. Interesting enough, the three patients moved to Canada. The three patients were advised to see local medical doctors in Canada. One patient was seen by the clinic doctors only once. At this time, they made a diagnosis of carcinoma of the left breast with extensive metastasis, recommended terminal care and discharged her from the clinic. (The arrangements for terminal care in a nursing home were made by the case worker.)

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### Social Services To Patients

It is a policy of the tumor clinic that all

TABLE XIII

the patients who are referred to the tumor clinic be seen by the medical social worker.

#### REASONS FOR DISCHARGES AND SEX DISTRIBUTION OF PATIENTS

The fifty-seven patients in the group being

Reason for Discharge	Total	Male	Female
Total	16	7	9
Completed treatment	5	2	3
Moved	3	1	2
Died	2	1	1
Private case of clinic doctor	2	2	-
Discharged to other clinics in hospital	2	-	2
Discharged to the Children's Hospital	1	1	-
Terminal care	1	-	1

One of the patients received limited service from a worker in another clinic in the outpatient department and three received comprehensive case work treatment in other clinics.





### Social Services To Patients

It is a policy of the tumor clinic that all the patients who are admitted to the tumor clinic be seen by the medical social worker on their initial visit.

The fifty-seven patients in the group being studied were all seen by the medical social worker upon admission to the clinic. Four of the patients in the total group received limited services from the case worker, besides their initial contact on their first visit. The types of services given to these patients were interpretation to families, arrangement for terminal care, referral to the Children's Hospital, and supportive treatment. Four other patients were referred to the case worker for social reviews. A total of eight patients (fourteen per cent) received additional services of the case worker aside from the initial contact all patients had with her on their first visit to the clinic.

One of the patients received limited service from a worker in another clinic in the outpatient department and three received comprehensive case work treatment in other clinics.





## CHAPTER V

## CASE ILLUSTRATIONS

There were nineteen patients (thirty-three per cent) in the group under consideration in this study who failed to return to the clinic. These reasons have been stated in the last chapter.

A more detailed account of the writer's personal contact with some of the patients and an interpretation and analysis of their feelings and attitudes will be given in this chapter. Only one contact was made with the patients. For this reason, a thorough analysis and interpretation of their reasons is not possible on the basis of too little information.

The problem of getting a patient to accept and submit to surgery is a difficult one sometimes, and not uncommon in a tumor clinic. The following abstracts indicate this situation.

Case I

Mrs K, a seventy-six year old widow, of German birth, was referred to the tumor clinic by one of the doctors in the cardiac clinic of the Massachusetts Memorial Hospitals where she was being treated for hypertensive cardiovascular disease. Mrs. K was referred





because of a mass in her right breast. The doctor in the tumor clinic felt that although the mass was probably benign, the patient "should be admitted for approximation and appropriate treatment." She only came this one time to the clinic, and failed to carry out the recommendation advised by the doctor.

"I did not want to have it done. I was scared. I don't want to go through another operation since it doesn't pain me," was Mrs. K's stated reason for not returning to the clinic. She verbalized more about this and told the investigator that she had three major operations and could not even think of undergoing another one. The operations were: (1) removal of the uterus; (2) removal of the gall bladder; (3) removal of the appendix and an abdominal tumor. The patient said the doctor in the cardiac clinic agreed with her, adding: "he did not blame me for not wanting to go through with another operation." In response to the investigator's question whether she received the clinic's follow-up card she replied, "I don't know." This developed into her telling of the problems created by her poor vision, and how good her children are to her. The children are all married and living away from home. She proudly told that in spite of her poor vision, she lives alone and is not too great a burden on anyone. Her daughter visits regularly and attends to the mail and neighbors bring her in groceries. She gave the information that her daughter returned the clinic's questionnaire<sup>1</sup> and she is willing to return to the clinic for a free check-up. She said in connection with returning to the clinic, "I know in this regard I'm all





right, but the lump has increased and several new ones have begun." She demonstrated this to the investigator. Her attitude about the clinic was not expressed. She had been a patient in the cardiac and medical clinics for several years, and told of all they had done for her, giving the doctors in these clinics credit for being alive.

This patient had three previous operations and was threatened by the thought of a fourth one. In spite of her stated fears in her reason for her failure to follow the doctor's recommendation for surgery, she is willing to return. The patient's age should be considered in terms of her rejection of this particular operation, as well as the fact that she is not suffering physically from her symptoms. She did express anxiety over the increase in size of the original mass and the appearance of several new tumors in this same area. The only feelings she expressed about the tumor clinic are manifested in her refusal to accept the recommendation of the clinic doctor.

Cockerill<sup>2</sup> has said that fears of mutilation, of giving up part of themselves, of castration, may be strong deterrents to the acceptance of medical recom-

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See Appendix C and D.

2

Eleanor Cockerill. "Adventures In Understanding," The Family, 20:159, July 1939.





mendations and it becomes very important to discover these feelings when the patient is showing blocking in going ahead with medical care and recommendations.

### Case II

Mrs. T, a thirty-nine year old female patient, was referred from the medical clinic with a question of a lipoma on her back. She was seen only once in the clinic at which time she was advised that she should be admitted to the hospital immediately for a total excision of the lump. The impression was a lipoma with a question of neoplastic changes. The arrangements were made for her to be admitted to the hospital. She failed to carry them out. A follow-up letter was sent which she failed to answer. She also neglected to return the questionnaire.<sup>3</sup>

Mrs. T was not at home twice when the writer visited. Her married daughter who lives with the patient gave the information that her mother was deathly afraid to be operated on. She said her mother had the lump on her back for eight years or more. It only caused her discomfort and pain for about the six months prior to the time when she first did something about it. During these six months, she complained a great deal of the pain. Her back, accord-

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<sup>3</sup>

See Appendix C and D.





ing to the daughter, has not bothered her since she was told she should have the lump removed. Her daughter showed little understanding and was indifferent to her mother's condition. Her mother has not been to another doctor to her daughter's knowledge since her visit to the tumor clinic. Patient is able to work every day.

From the evidence, it is difficult to make any definite statement or interpretation. However, the writer would conjecture that the patient does not receive much support or understanding from her daughter who lives with her. Because of the daughter's indifference, the patient does not get an opportunity to express her feelings about her condition. The daughter's statement of the patient's deathly fear of surgery, her refusal to follow the recommendations, her ignoring of the follow-up letter and failure to return the questionnaire<sup>4</sup> might perhaps indicate that this patient has a fear of surgery. The basic reason for this fear is unknown. It is perhaps possible that the pain which the patient complained of the six months before she sought medical advice, was obliterated by a more intense fear of surgery. It is unknown what induced the patient to seek advice after such a long period of suffering. It was impossible to determine what

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<sup>4</sup>Ibid.





kind of an experience she had while at the clinic and whether or not any threatening information was given to her at this time.

### Case III

This seventy-eight year old man, Mr. G, who was still actively engaged in religious work came to the tumor clinic of his own accord because of the appearance of a lump on his neck. He came twice to the clinic. On the second visit, the impression was a question of a lipoma on the patient's neck. He was advised that an excision should be done. The patient was told he would have to remain in the hospital only over-night. He wanted to decide whether he would be admitted as a private or a staff patient. The arrangements were postponed until the patient made his decision and he was to advise the social worker in the clinic as to his decision. He failed to contact the clinic after the second visit.

Mr. G's initial statements in regard to why he did not carry out the clinic doctor's recommendation were: "I consulted another doctor who said it did not appear serious to him, so I forgot about it. I have regular examinations and I'm in perfect condition for my seventy-eight years." He changed the subject and showed a group picture he had just received including eight of





his children, thirty-two grand-children, and eleven great-grand-children. This developed into a discussion of his family. In the middle of the discussion, totally irrelevant to what was being discussed, the patient opened his collar and showed the lump on his neck. He spoke with concern about the fact that the lump changed in size. "It gets big and then decreases. It never bothers me, so it would be nonsense to let them cut it." His wife became upset when he mentioned having the lump excised. She said, "He is fine and doesn't need to be cut; it would only be looking for trouble. It's better to leave it alone since it doesn't pain or bother him." Mr. C returned the questionnaire<sup>5</sup> to the clinic. He is willing to return to the clinic when they send him a new appointment. "It doesn't bother me, but I'll let the doctor look at it."

This patient was given some reassurance by the doctor whom he consulted after the clinic recommended that he have the lump removed, who told him: "It did not seem serious to him." The patient also gets satisfaction out of his regular physical examinations and from being told he is in perfect condition. The patient is mentally alert and very active for a man of his age. His religious work and faith is another factor of reassurance for the patient. He did manifest anxiety over the fact that the tumor changed size, and unconsciously reassured himself that it





was not serious because it was not painful. He is willing to return to the clinic which is an admission of concern about his condition in spite of his statement that he is in perfect health.

The following abstract illustrates a patient who failed to keep her appointments in the clinic.

#### Case IV

Mrs. H was a sixty-nine year old married woman who was referred to the tumor clinic by a local skin specialist with the complaint of "a lesion of the left temporal area of hair line." A diagnosis of lymph-angio-endothelioma was made. The pathology reported stated: "No evidence of malignancy." She was treated with X-ray and kept eleven clinic appointments faithfully and then failed to return.

"The weather was too much. It was too hot and then it was winter before I knew it. I'm afraid of the ice," was patient's initial statement for not keeping her appointments. At the time of her last visit to the tumor clinic the patient said the doctor suggested that she go back to see the doctor who referred her to the clinic to let him see how she was getting along. This she did not do. She gave the information in the interview that other than to have her babies, she had had no other personal relationships with doctors until going to the referring doctor about the lesion on her forehead. The only reason she went was





that her sons insisted for so long. Her reason for resisting seeing a doctor sooner was: "I was afraid I might hear something I did not want to." She spoke of her dislike for doctors and hospitals. This woman had a son die thirty years ago. The cause of his death was a tumor. He was treated at the Boston Dispensary with radium. Mrs. H wiped tears from her eyes as she talked of her son who died. He was her baby. She said, "I don't want to die. I want to live a long time, but still don't want to be a burden." This was said when her husband said that he had lived a full life and had seen his grand-children come into the world. Her husband showed much interest in his wife's condition and has urged her to return to the clinic as have her five sons. Her last visit to the clinic was on a very humid morning in June and she had to wait some time to be seen by the doctors. She returned the questionnaire and assured worker she would return when sent an appointment. A follow-up card was sent which patient did not receive.

This is a situation where something other than reality kept this patient from returning to the clinic. When this interview was made there had been a seven and one-half month's lapse since her last visit to the tumor clinic. During the patient's delinquency period, there were days where "the weather," her stated reason for failing to return, was favorable. The long wait on her last visit to the clinic and the suggestion to return to





the referring doctor was a threat to this woman who has an expressed dislike and fear of doctors and hospitals. It also appears as an important factor that she is identifying her condition with the son who died of a tumor. Primarily, it seems that the basis for this patient's not keeping her appointment in the clinic is fear--fear of doctors, fear of disease, fear of death.

The following illustrations indicate the more realistic reasons given by the patients for not keeping their clinic appointments.

#### Case V

Mr. D, an eighty-three year old man was referred to the tumor clinic by a local medical doctor because the patient had a lesion on his cheek. A biopsy was done and the pathology report read "basal cell carcinoma." The patient was treated with a series of X-ray and for five months kept his clinic appointments. On his last visit to the clinic, Mr. D was told to return in three months and was given an appointment for the date he was to return. He failed to keep this appointment and was sent a routine follow-up card. His daughter came in to the clinic and told the social worker that he was not able to go out in the snow and ice.





Mr. D's initial comment in reply to investigator's question as to why he had stopped coming to clinic was: "Haven't been out since October due to the bad weather. I fractured my hip two winters ago and don't dare attempt the ice. I've got a hiatus hernia that is terribly painful. It keeps me up all night long." The patient then described in detail his hernia and all the medical care and doctors he has had. He needs an operation for his hernia, but rejects surgery: "I don't care how long I live now. I've had everything money could buy in my day. No more cutting or chiseling for me." The patient also has cataracts and his vision is very poor. He told investigator that he was going to go back to the clinic soon, now that the weather was improving. "This thing on my face doesn't bother me at all. I had it treated over at the hospital with X-ray. It was unbearable but I stuck to it." He knew his diagnosis and spoke of it as having been cancer with no apparent concern. He demonstrated a new lump which has recently appeared on his cheek and added, not too convincingly, that it was nothing more than a few ingrown hairs from his beard.

This patient's initial reason as to why he did not keep his appointment was a realistic one--the weather. He then went into a detailed description of his hernia and cataracts. This may or may not have been a cover-up for his unconscious anxiety later manifested over the appearance of the new lump on his face. He knew that he was being treated in the tumor clinic for a skin cancer,





and spoke of this fact very objectively and without much feeling or concern. In view of this, there is a possibility that he was fearful that the new lump on his face was also cancerous. He may have been rationalizing to cover up this fear and reassure himself that it was nothing more than a few ingrown hairs from his beard.

#### Case VI

Mrs. W, a seventy-two year old woman, was referred to the tumor clinic for follow-up from the surgical follow-up clinic with a diagnosis of basal cell carcinoma of the upper right lip. She was seen three times, each visit two months apart. She failed to keep her fourth appointment. The patient was a nurse.

"The weather has been too bad," was Mrs. W's reason for not keeping her appointment. She fell on the ice the first snow fall and had not been out of the house all winter since she fell. She feared another accident. She lived in an out-lying district and transportation was also a problem. Mrs. W expressed no concern over her condition other than she felt it was checked. She responded to the questionnaire<sup>7</sup> (and since the time of this contact, she has returned to the clinic). Her attitude towards the clinic was positive.

This patient's stated reason, namely, the weather, was a realistic one for not keeping her appointments during





the winter months. She is seventy-two years old and it is understandable that she was fearful of the snow and ice, especially having had the experience in the early winter of falling. She did not show any obvious negative feelings about cancer. This possibly may be explained by the fact that this patient was a nurse, as well as by the fact that she had responded very well to therapy. Her status in the clinic was for observation. Her positive attitude toward the clinic may be due to some degree to the fact that she was diagnosed and treated elsewhere and was only receiving follow-up care in the clinic.

#### Case VII

This patient, M, referred by a local medical doctor was three months old when she was admitted to the tumor clinic with a question of a hemangioma on her leg. A diagnosis of a hemangioma was made on the child's first visit to the tumor clinic. Twelve appointments were kept regularly after which time it appeared from her record that she failed to keep her appointment.

The father's reply in answer to the question why the child had not returned to the clinic was: "They were told by the doctor not to bring her back for six months; to wait and see what developed." Unknown to the investigator, a week prior





to contact with the parents, they had brought the child into the clinic. Only five of the six months they were advised to wait before returning had lapsed. Their return was promulgated by their receiving the clinic's questionnaire.<sup>8</sup> They returned to the next meeting of the clinic following their receiving it. The parents were interested and concerned over the child's health. They had a positive attitude towards the clinic and were very happy about the interest the clinic has shown in their daughter.

Actually this patient does not belong in the group of delinquent or non-returning patients. It was a clinical oversight in that the fact that the parents were advised by the doctor to wait for six months was missing from the child's record. The parents were willing to return. This is indicated by their immediate response to the questionnaire.<sup>9</sup> This action on the part of the parents is indicative of the concern and anxiety they have over their daughter's condition. In this particular instance, the questionnaire<sup>10</sup> may have been a real threat to the parents of this patient.

#### Case VIII

Miss P, a twenty-one year old girl was referred to the tumor clinic by her family doctor because of a

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<sup>8</sup>

See Appendix C and D.

<sup>9</sup>

Ibid.

<sup>10</sup>

Ibid.





rough lump on her heel. The tumor clinic's doctor's impression was that the lump resembled a verruca. The patient was advised that she should be admitted to the hospital for an excision of this lump. She was told she would have to rest and use either a cane or crutches for a few weeks after the operation. Miss P at this time was to start a new job within three days and did not feel she could spare the time. She was to contact the clinic at a later date to arrange for the excision. The patient came to the clinic only once and to the knowledge of the clinic failed to follow the recommendations. The patient was seen in the clinic only once.

Miss P advised investigator that she had the excision done privately by one of the tumor clinic's doctors about two months after her visit to the clinic. She had Blue Cross and Blue Shield Insurance and her family doctor made the arrangements with the clinic doctor to have her admitted as a private case. The region was benign. She had an intelligent attitude toward cancer, and realized she had a pre-cancerous condition. The lump has commenced to reappear and she is anxious to return to the clinic for additional treatment if this is indicated, as she cannot afford to pay for private care. She returned the questionnaire<sup>11</sup> to the clinic and will return when she is sent an appointment. A growth of warts have appeared on her hands and she wished to have these taken care of in the clinic. She has a good understanding of

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<sup>11</sup>

Ibid.





the preventive measures to be taken to guard against cancer and discussed her knowledge in terms of her own symptoms with a great deal of insight. Her family is interested and intelligent and support her and encourage her to safeguard herself against cancer. They spoke of the disease with remarkable objectivity.

This patient's reason for not returning was that she was operated on as a private patient. This illustrates a problem which patients may have if they carry Blue Cross and Blue Shield Insurance and are clinic patients. She is still eligible to return for follow-up care in the clinic, but this was not explained to the patient. Her attitude toward disease is favorable. Since only one contact was made with the patient and her family, it is difficult to evaluate how objective they really are. On the surface, they showed no fear or concern about cancer. This is the goal of the educational branch of the American Cancer Society. The writer questions whether this girl had an unconscious fear of cancer, in spite of her apparent intelligent understanding of the preventive measure. Weiss and English have made the following observation.

...with all the propaganda for the early detection of cancer these fears are exaggerated and we presume it is the price that we pay for instructing people about cancer. We are not, of course, advising





against such instruction; it is only that we must realize that we add to the apprehension of many patients by our emphasis upon the early detection of cancer.<sup>12</sup>

The purpose of this study was to determine the reasons for patients' failure to return to the tumor clinic at the Massachusetts Memorial Hospital. The study was designed to determine (1) the cooperation or social characteristics of the patients studied, (2) the extent to which the total group received treatment for their original complaint, (3) the proportion of patients who failed to return, (4) the reasons for their failure to return, and (5) the proportion receiving treatment elsewhere and still being followed.

A necessary part of understanding the behavior of tumor clinic patients is a knowledge of the medical information on benign and malignant tumors. A summary of the medical information on tumors was presented in order that the reader might have a background towards understanding the group of patients considered in this study. A brief review of the efforts being made for the control of cancer was given. The Massachusetts State Cancer Program was included in view of the fact that it contains cancer prevention.





## CHAPTER VI

## SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to determine the reasons for patients' failure to return to the tumor clinic at the Massachusetts Memorial Hospitals. The study was designed to determine (1) the composition or social characteristics of the patients studied, (2) the extent to which the total group received treatment for their original complaint, (3) the proportion of patients who failed to return, (4) the reasons for their failure to return, and (5) the proportion receiving treatment elsewhere and still being followed.

A necessary part of understanding the behavior of tumor clinic patients is a knowledge of the medical information on benign and malignant tumors. A summary of the medical information on tumors was presented in order that the reader might have a background towards understanding the group of patients considered in this study. A brief resume of the efforts being made for the control of cancer was given. The Massachusetts State Cancer Program was included in view of the fact that it centers around prevention.





All of the patients admitted during the first six months in 1947 were studied. There were fifty-seven patients. All age groups and both sexes were represented. Females totaled seventy per cent; males totaled thirty per cent. (See Table I, page 25). Seventy-seven per cent were thirty-five years of age and over. Forty-nine per cent were between thirty-five and sixty-four years of age. The largest single group was between thirty-five and sixty-four years of age. Twenty-three per cent were under thirty-five years of age.

Nine different nationality groups were represented, the largest being sixty-one per cent American born. The second largest groups were Canadian and Irish respectively. (See Table II, page 28).

Sixty per cent of the patients were married at the time of admission to the clinic. (See Table III, page 29). The vocations of the patients were varied, although sixty-seven per cent were concentrated mainly in the domestic and personal group. The next largest group were the manual and mechanical group, constituting fourteen per cent. (See Table IV, page 31).

Twelve patients or twenty-one per cent had diagnoses of malignant tumors or cancer. Sixty per cent of the patients had definitely stated diagnoses and forty





per cent were classified as impressions. (See Table V, page 34 and Table VI, page 37). The large proportion of patients where the diagnoses were only impressions is accounted for by the fact that many of the patients failed to return to the clinic after their first or first few visits.

The patients' status in the clinic revealed that sixteen patients or twenty-eight per cent were discharged from the clinic. (See Table XIII, page 49). Six patients or eleven per cent were referred to other clinics in the hospital. All but one followed this recommendation. Thirteen patients or twenty-three per cent have kept their appointments and the other patient has returned to the clinic. This makes a total of nineteen patients (thirty-three per cent) who are still under observation or treatment. Three of the patients or five per cent preferred private care. In the group studied, nineteen patients (thirty-three per cent) failed to return for observation or to follow recommendations.

Included among the nineteen patients who failed to return for observation or treatment were thirteen patients who were advised that hospitalization and surgery were indicated. Eight of these patients followed the recommendations. Five of the patients were admitted





as staff patients and followed in the surgical follow-up clinic; two were admitted as private cases; one patient was a veteran and she was operated on and followed post-operatively in the Chelsea Naval Hospital. The patients who were followed in the surgical follow-up clinic did not return to the tumor clinic after they were discharged from this clinic. This fact might indicate that they were not advised to return to the tumor clinic for further follow-up. This is supported by the patients' response to the clinic's questionnaire.<sup>1</sup>

Follow-up in the case of clinic patients is most important. There were five patients who refused hospitalization. One patient felt it was useless and this is understandable in view of the seriousness and corresponding emotional implications of such a recommendation. Four of the patients feared surgery. Table X, page 42 illustrated the reasons for the remaining patients' failure to return. These facts illustrate the need for a medical social worker available to interpret to the patients and to follow-up in order to decrease the number of patients who fail to follow recommendations.

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<sup>1</sup>

See Appendix C and D.





Twenty patients (thirty-five per cent) were being followed in other clinics or by private doctors and are still being followed or considered as clinic patients. Twenty-one per cent of the patients writer found were being followed elsewhere, although this was 'unknown' to the clinic. Fourteen per cent of the patients who were being followed in other places had the information recorded on their tumor clinic medical records. The clinic secretary was able to give this information verbally in many instances. This is an administrative detail that could be rectified.

Five patients (nine per cent) received complete treatment in the tumor clinic for their original complaint. A total of sixteen patients (twenty-eight per cent) were discharged. (See Table XIII, page 49). Seventy-nine per cent of the patients received partial treatment in the clinic. Included in this seventy-nine per cent are thirty-three per cent of the patients who are still being followed or treated in the clinic. Twelve per cent of the patients received no treatment for their original complaint. These seven patients failed to carry out the recommendations for treatment.

Four of the patients received limited services from the case worker, and four others were given comprehensive case work treatment. All of the patients were





seen by the clinic social worker on their initial visit to the clinic. The only patients receiving the case worker's services were those referred specifically by the doctor to the case workers. From the group of patients studied, it indicates that the worker should have more freedom and available time to handle the medical-social problems as they arise with each patient.

Case illustrations of patients who fail to keep their appointments or follow the clinic doctor's recommendations were presented in order to give the reader a clearer picture of the reasons patients failed to return to the clinic. Many of the social dynamics surrounding tumor clinic patients were evident.

Recommendations for follow-up treatment.

III. The coordination of the administrative details of the tumor clinic and the cooperation of the other clinics in the hospital in this regard.

The clinic is aware of the limitations of its services at the present time. It is in the process of completing an extensive follow-up study. This study will further clarify and ultimately lead to the alleviation of many of the weaknesses on which the writer based her recommendations.

Richard K. B. [Signature]





### Recommendations

In consideration of the evidence presented in this study, the following recommendations are made:

I. The organization of a system of social review for all tumor clinic patients. This review should involve a social study of all patients by the social worker in order that medical-social needs might be recognized, evaluated and dealt with. This would necessitate a sufficient number of workers being included on the staff to give the services required to meet the patients' needs.

II. The establishment of an intensive follow-up system for all patients who fail to keep clinic appointments or follow treatment recommended.

III. The coordination of the administrative details of the tumor clinic and the cooperation of the other clinics in the hospital in this regard.

The clinic is aware of the limitations of its services at the present time. It is in the process of completing an extensive follow-up study. This study will further clarify and ultimately lead to the alleviation of many of the weaknesses on which the writer based her recommendations.

*Richard H. Grant*





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## APPENDIX A

ScheduleName:Diagnosis:Address:Impression:Date of Discharge:

- 1.) a. Diagnosis made after \_\_\_\_\_ visits.  
 b. No diagnosis made \_\_\_\_\_ a. Impression

2.) Where recommendations followed?

a. Treated in Tumor Clinic.

1. Completed treatment \_\_\_\_\_

2. Still being followed \_\_\_\_\_

3. Failed to return after \_\_\_\_\_ visits.

b. Referred to other clinic, in hospital.

1. Did patient go? \_\_\_\_\_

c. Referred into hospital.

1. Was patient admitted? \_\_\_\_\_

2. Was patient treated as \_\_\_\_\_

3. Where was patient followed? \_\_\_\_\_

## APPENDICES

3.) Did patient receive treatment by Tumor Clinic for original complaint?

1. Complete \_\_\_\_\_

2. Still under treatment or observation \_\_\_\_\_

3. Treatment terminated by patient \_\_\_\_\_

4. Referred to other clinic in hospital. \_\_\_\_\_

5. Discharged to other clinic in hospital. \_\_\_\_\_

4.) Was patient discharged from Tumor Clinic?

1. No immediate treatment indicated \_\_\_\_\_

2. No further treatment indicated \_\_\_\_\_

3. Terminal care \_\_\_\_\_

4. Moved \_\_\_\_\_

5. Died \_\_\_\_\_





## APPENDIX A

ScheduleName:Diagnosis:Address:Impression:Date of Discharge:

- 1.)
  - a. Diagnosis made after \_\_\_\_\_ visits.
  - b. No diagnosis made \_\_\_\_\_ c. Impression \_\_\_\_\_
- 2.) Where recommendations followed?
  - a. Treated in Tumor Clinic.
    1. Completed treatment \_\_\_\_\_.
    2. Still being followed \_\_\_\_\_.
    3. Failed to return after \_\_\_\_\_ visits.
  - b. Referred to other clinic, in hospital.
    1. Did patient go?
  - c. Referred into hospital.
    1. Was patient admitted. \_\_\_\_\_.
    2. Was patient followed after discharge? \_\_\_\_\_.
    3. Where was patient followed? \_\_\_\_\_.
  - d. Referred back to referring doctor.
    1. Did patient return? \_\_\_\_\_.
- 3.) Did patient receive treatment by Tumor Clinic for original complaint?
  1. Complete \_\_\_\_\_.
  2. Still under treatment or observation \_\_\_\_\_.
  3. Treatment terminated by patient \_\_\_\_\_.
  4. Referred to other clinic in hospital.
  5. Discharged to other clinic in hospital.
- 4.) Was patient discharged from Tumor Clinic?
  1. No immediate treatment indicated \_\_\_\_\_.
  2. No further treatment indicated \_\_\_\_\_.
  3. Terminal care \_\_\_\_\_.
  4. Moved \_\_\_\_\_.
  5. Died \_\_\_\_\_.





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77

APPENDIX A (Continued)

5.) Did patient receive service of the Tumor Clinic  
Social Worker?

Yes

No

Type of service

DATE OF LAST VISIT:

RENT:

NO. OF ROOMS:

DATE OF ADMISSION:

REFERRING AGENT:

DIAGNOSIS:

DID PATIENT RECEIVE IT?

WAS PATIENT SENT FOLLOW-UP CARD?

PATIENT'S STATED REASON FOR NOT  
RETURNING.

ATTITUDE TOWARD CLINIC:

ATTITUDE TOWARD DISEASE:

FAMILY'S ATTITUDE:

IS PATIENT UNDER CARE OF ANOTHER CLINIC OR PRIVATE DOCTOR  
AT PRESENT?

SOCIAL WORKER'S INTERPRETATION OF REASON FOR PATIENT'S  
DELINQUENCY.





## APPENDIX B

NAME:NO. IN FAMILY:ADDRESS:LIVING AT HOME:BIRTH DATE:AGE:SEX:MARITAL STATUS:RESPONSIBILITYINCOME:DATE OF LAST VISIT:RENT:      NO. OF ROOMS:DATE OF ADMISSION:REFERING AGENT:DIAGNOSIS:DID PATIENT RECEIVE IT?

WAS PATIENT SENT FOLLOW-UP CARD?

PATIENT'S STATED REASON FOR NOT  
RETURNING.

ATTITUDE TOWARD CLINIC:

ATTITUDE TOWARD DISEASE:

FAMILY'S ATTITUDE:

IS PATIENT UNDER CARE OF ANOTHER CLINIC OR PRIVATE DOCTOR  
AT PRESENT?SOCIAL WORKER'S INTERPRETATION OF REASON FOR PATIENT'S  
DELIQUENCY.





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79

APPENDIX C

MASSACHUSETTS MEMORIAL HOSPITALS  
SOCIAL SERVICE DEPARTMENT  
82 East Concord Street  
Boston 18

Date:

My dear

We find in looking over your record that we have not seen you in the Tumor Clinic since. The doctors would like to hear how you are feeling and would appreciate it if you would answer the enclosed questionnaire.

When you have filled this in please return it to us. We would be grateful for your attention to this and your returning the questionnaire as promptly as possible.

Very truly yours,

Rebecca H. Poole  
Medical Social Worker

RHP/pa





## APPENDIX D

## QUESTIONNAIRE

If patient is unable to answer the following questions  
would some member of the family please do so.

1. Have you any signs of any return of the trouble that brought you to the clinic?
2. Have you any new symptoms?
3. Have you had any hospitalizations since your last visit? If so, name of hospital, date of admission, and for what reason you were hospitalized.
4. Are you under the care of a private doctor? If so, what is his name and address.
5. Would you be willing to return to the hospital sometime in February for a free check-up, the appointment date to be sent to you later?
6. Any additional information which you would like to give us.

Your name:

Present address:

Telephone number:

Please mail this back to us.





## APPENDIX E

MEDICAL WORD LIST<sup>1</sup>

Biopsy	- examination of tissue taken from a living body.
Cancer	- crab, devouring sore. Any malignant growth.
Carcinoma	- a malignant epithelial tumor.
Cyst	- a sac containing fluid.
Epithelial	- pertaining to epithelium.
Epithelium	- a term applied to cells lining parts of body in communication with the external air, and also those specialized for secretion in certain glands, such as the liver, kidney, or stomach.
Etiology	- the causation of disease.
Excision	- surgical removal of growth.
Hemangioma	- tumor composed of blood vessels.
Heredity	- the transmission of qualities from ancestor to offspring.
Hiatus hernia	- a hernia through the diaphragm.
Hodgkins disease	- a disease of the lymph nodes.
Lipoma	- a fatty tumor.
Lymphangio- endothelioma	- a growth arising from the lymph vessels.
Malignant	- threatening life, virulent.

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The Committee on Publication. Cancer Control.  
 The What - Whither - How, pp. 49, 50, 59, 71.





**Malignant  
tumor**

- a tumor composed of cells of unre-  
stricted growth which may spread to  
other parts of the body.

**Metastasis**

- transferring of diseased cells from  
their place of origin to distant parts  
of the body through the blood vessels  
or lymph channels.

**Precancerous**

- a condition occurring before the de-  
velopment of a carcinoma.

**Radium**

- a chemical element which is radio-  
active.

**Sarcoma**

- a malignant, connective tissue tumor.

**Tumor**

- a new growth serving no useful purpose  
to the body.

**Verruca**

- a wart.

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